STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185381	A. BUILDING _____ B. WING _____	C 08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HART COUNTY HEALTH CARE CENTER	1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY15157) was conducted on August 11-12, 2010. The allegation was unsubstantiated, however, deficient practice was identified with scope and severity at "D" level.	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain clinical records for one (1) of three (3) sampled residents (resident #1) that were complete and accurately documented. Record review revealed resident #1 had a temperature of 100.1 degrees Fahrenheit and an oxygen saturation of 81 percent with wheezing noted on July 24, 2010, at 6:55 p.m. Interview revealed Licensed Practical Nurse (LPN) #2 administered a breathing treatment and Tylenol to resident #1 and the resident's oxygen saturation increased to 92-93 percent. This information was not completely documented in resident #1's medical record. The	F 514	Licensed staff was inserviced on 7/26/10 in regards to documenting the actions they take regarding the care of residents in the medical record. The nurses involved with this incident were reprimanded for their lack of documentation. A 100% audit was completed on all current medical records on 7/27 to ensure that any acute event was documented and had the appropriate interventions. This was completed by Administrator and nursing administration. Education for licensed staff/CMTS was completed on 9/1/10 that any time they give a routine or PRN medication they need to initial this off on the MAR.	9-10-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 9-8-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 514	Continued From page 1 review further revealed on July 24, 2010, at 11:30 p.m., resident #1 had a temperature of 99.2 degrees Fahrenheit. The nurse's note stated LPN #1 administered a breathing treatment; however, there was no documentation of the LPN administering Tylenol as revealed in interview with LPN #1. LPN #1 stated around 1:30 a.m., the resident's temperature was 99.7 degrees Fahrenheit, and the LPN again administered a breathing treatment and Tylenol to resident #1 and the resident's oxygen saturation was still 92-93 percent. However, LPN #1 did not document the 1:30 p.m. medications or assessment. The findings include: A review of resident #1's nurse's notes revealed on July 24, 2010, at 6:55 p.m., resident #1's face was flushed with a temperature of 100.1 degrees Fahrenheit and oxygen saturation of 81 percent with wheezing noted; however, the resident denied any difficulty breathing. The nurse's note stated the resident's heat was on low heat which was turned to low cool. Review of the Vital Sign Record revealed resident #1's vital signs were taken at 6:55 p.m., and the resident's respirations were 20 with a blood pressure of 86/50. An interview conducted on August 11, 2010, at 5:10 p.m., with LPN #2 revealed State Registered Nurse Aide (SRNA) #2 reported at 6:55 p.m., that resident #1's face was flushed. The interview revealed LPN #2 assessed resident #1 and found the resident's oxygen saturation in the 80's and the resident had a low grade temperature. LPN #2 reported the LPN administered a breathing treatment and Tylenol to resident #1 and the resident's oxygen saturation increased to 92-93	F 514	A pharmacy representative is providing training on documentation 9/9/10. This will include documenting MAR's/TAR's appropriately and the importance of documenting in the resident medical record of actions taken monitoring resident assessments. The facility is monitoring the 24 hour report sheets to follow-up on documentation to ensure nurses notes are being made according to the care being provided. Any deficient area is corrected at this time with the necessary education. This is being completed by Administrator or designee. The facility will monitor the MAR's to ensure that medications are administered and initialed off per MD orders. This will be reviewed by the Administrator or designee. The QA Committee will review the tracking form for no less than 3 months to ensure compliance.	

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F 514	Continued From page 2	F 514		

percent. The interview revealed the above information was passed on to LPN #1, the oncoming 7:00 p.m. shift nurse. LPN #2 confirmed the LPN had failed to document the administration of the breathing treatment or the fact that the resident's oxygen saturation increased to the 90's following the breathing treatment.

A review of resident #1's nurse's notes dated July 24, 2010, at 11:30 p.m., revealed the resident's temperature was 99.2 degrees Fahrenheit and the resident was flushed and congested. The nurse's note stated LPN #1 administered a breathing treatment and the resident requested to be gotten up to the recliner.

An interview conducted on August 11, 2010, at 5:00 p.m., with LPN #1 revealed the LPN was informed by LPN #2 during shift report on July 24, 2010, that resident #1 was congested with a low grade temperature and had been administered a breathing treatment and Tylenol. LPN #1 stated around 11:00 p.m., the resident's temperature had decreased to 99.2 degrees Fahrenheit and the LPN administered a breathing treatment and Tylenol to the resident and the resident's oxygen saturations were 92-93 percent. The LPN stated the resident's vital signs were obtained around 1:30 a.m., and the resident's temperature was 99.7 degrees Fahrenheit, blood pressure was 100/68, and the resident's respirations were 20. The interview revealed LPN #1 again administered a breathing treatment and Tylenol to resident #1 and the resident's oxygen saturation remained at 92-93 percent. However, LPN #1 did not document the administration of the breathing treatment or the Tylenol at 11:00 p.m., in the resident's Medication Administration Record

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F 514	Continued From page 3 (MAR). The LPN also failed to document the 1:30 p.m. medications or assessment on the nurse's notes or the MAR. Interviews revealed resident #1 requested to be transferred from the bed to the recliner, however, had no complaints.	F 514		